RESIDENTIAL TREATMENT CENTER (RTC) SERVICES PROGRAM

3400 INTRODUCTION

Residential Treatment Center (RTC) services are delivered in psychiatric, medical-model facilities, in-state or out, that are accredited by the Joint Commission on the Accreditation of Healthcare organizations (JCAHO). The objective of RTC services is to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders, or conditions, who are no longer at or appropriate for an acute level of care, but who meet medical necessity for RTC admission and length of stay criteria, to address these disorders, in a less restrictive environment.

RTCs are part of the mental health continuum of care. Recipients who respond well to treatment in an RTC may eventually be discharged to a lower level of care, such as a social model group home, therapeutic foster home, intensive community-based services, or to the intermittent care of a psychiatrist or psychologist.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

3401 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation to states that elect to offer medical programs. The states must offer the 11 basic required medical services. Federal Financial Participation (FFP) is also available should states elect to cover some optional services. One of these services is inpatient mental health services to persons under age 21, pursuant to 42 CFR 440.160. Additionally, the state Medicaid program is required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as a result of an EPSDT (Healthy Kids) screening, whether or not such services are covered under the state plan (section 1905 (a) of the Social Security Act). As such, Nevada Medicaid covers services rendered in residential treatment centers (RTCs) as an optional program benefit.

Other authorities include:

Section 1905 (h) of the Social Security Act (Inpatient Psychiatric Services to Individuals Under Age of 21)

Section 1905 (i) of the Social Security Act (Definition of an IMD)

Section 1905 (r) (5) of the Social Security Act (Mental Health Services for Children as it relates to EPSDT)

42 Code of Federal Regulations (CFR) 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21).

42 CFR 441.150 to 441.156 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)

42 CFR 483.350 to 483.376 (Condition of Participation for the use of restraints or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age of 21).

Nevada Revised Statutes (NRS) 433.B.010 to 433.B350 (Mental Health of Children)

Nevada Medicaid State Plan, section 419.A., page 5.

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
Restraint and Seclusion Standards for Behavioral Health.

Nevada Medicaid Residential Treatment Center (RTC) Policies, Procedures and Requirements

3402 DEFINITIONS

3402.1 ADMISSION

Nevada Medicaid considers a recipient admitted to the RTC as an inpatient when 1) the physician writes the order for admission; and 2) the admission has been certified by Nevada Medicaid's Quality Improvement Organization (QIO-like vendor).

3402.2 MENTAL HEALTH REHABILITATION TREATMENT SERVICES

Mental Health Rehabilitative Treatment Services refer to those services which are provided with the primary purpose of treatment or rehabilitation of a mental disorder, or a dysfunction related to a mental disorder. Individuals must have a functional impairment in major life activities including substantial limitations in basic living skills, occupational-education adjustment, self-care, social/interpersonal skills or communication skills. All such services are reimbursable only when provided as a result of a referral from a licensed physician or other licensed practitioner of the healing arts. Services must be provided in accordance with a plan of care (as defined by 42 CFR 441.155) developed by the care coordinator.

Mental Health rehabilitation services available to Medicaid recipients which are determined by their eligibility, include, but are not limited to, intensive community-based treatment, partial care, skills training, therapy, foster care and residential treatment (under age 18), and residential rehabilitation, crisis intervention and independent living training (age 18 and over).

All services will be provided by a state employee, agency or contractor of the Nevada Department of Human Resources.

Please refer to Medicaid Services Manual, Chapter 2900, entitled "Mental Health Rehabilitation Services" for specific covered services and program limitations.

3402.3 MENTAL HEALTH SERVICES

Mental health services are those techniques, therapies, or treatments provided to a recipient who has an acute, clinically identifiable psychiatric disorder, as identified in the Diagnostic and Statistical Manual (DSM–IV) of Mental Disorders, for which periodic or intermittent treatment is necessary. These techniques, therapies, or treatments must be provided by a qualified mental health professional/clinician.

Mental health services are to be provided in a medical or problem-oriented format, which includes an assessment of the problem, a diagnosis, and a statement of treatment goals and objectives, recipient strengths, and appropriate community-based resources. Treatment should generally be short term and goal oriented or, in the case of chronic disorders, intermittent and supportive.

3402.4 RESIDENTIAL TREATMENT CENTER (RTC)

A Residential Treatment Center (RTC) is a mental health facility having 17 beds or greater, and designed as a medical model of therapeutic care. RTCs are self-contained and provide 24-hour secured (locked) inpatient care, treatment, and supervision for children and adolescents 20 years of age and younger. This setting provides an integrated and comprehensive array of services to meet the child's or adolescent's needs who cannot effectively be helped within his/her home, substitute family, or in a less restrictive environment. This includes, but is not limited to, treatment services (psychotherapies), educational services, psychological testing and evaluation, and a clinical treatment milieu designed to meet the individual treatment needs of each child.

RTCs specialize in treating children and adolescents with mental disorders including personality disorders, depression, hyperactivity, mild learning disabilities, and/or substance abuse disorders, as well as other clinical and behavioral psychopathologies. Recipients admitted to RTCs generally have experienced failed placements in the home, school, community, and have exhausted all local resources. They need a highly structured environment with a therapeutic program in a residential setting with 24-hour supervision. All recipients are provided individual, group and family therapy.

An RTC may exist as a freestanding facility or as a unit within a psychiatric hospital.

Nevada Medicaid only reimburses RTCs licensed by the State Health Division, Bureau of Licensure and Certification and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or out-of-state RTCs licensed by that state authority and JCAHO.

3402.5 SEVERE EMOTIONAL DISTURBANCE (SED)

Children with a severe emotional disturbance (SED) are persons:

a. From birth up to age 18; and

b. Who currently or at any time during the past year (continuous 12-month period):

Have a diagnosable mental, behavioral or diagnostic criteria specified that meets the coding and definition criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This excludes substance abuse or addictive disorders, irreversible dementias as well as mental retardation, and V codes, unless they co-occur with another serious mental illness that meets DSM-IV criteria;

That resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities, and

c. These disorders include any mental disorder (including those of biological etiology) listed in DSM-IV "V" codes, substance use, and developmental disorders, which are excluded,

unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and

d. Have a Functional impairment, defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit or treatment or other support services are included in this definition.

3403 POLICY

3403.1 RTC SERVICES

Nevada Medicaid reimburses for RTC services for recipients 20 years of age and under only if the services are prior authorized by Medicaid's QIO-like vendor.

3403.1A COVERAGE AND LIMITATIONS

1. Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications (for Axis I, II and III diagnoses), quarterly RTC-sponsored family visits, educational/academic services, and supervised work projects. The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, some dental, optometry, durable medical equipment, radiology, lab, and therapies (physical, speech and occupational). All of these services are Medicaid benefits which must be billed separately by the particular service provider. Some may require prior authorization (please see section 3405 of this chapter for cross-reference purposes).

2. The QIO-like vendor may authorize all RTC stays, fee for service and Health Maintenance Organization in three-month (or less) increments. For Medicaid recipients to remain in RTCs longer than three months, the RTC must, prior to the expiration of each authorization, submit documentation to the QIO-like vendor for a determination concerning an additional authorization. It is the RTC's responsibility to contact the QIO-like vendor no later than the 15th day of the month in which the current authorization expires. Please reference chapter 3600 for Managed Care coverage and limitations.

   For recipients under the age of 21 in the custody of the Nevada Division of Child and Family Services (DCFS), Nevada Medicaid will reimburse for RTC admissions and services only when the following criteria are met:

   a. DCFS' Regional Resource Council (RRC), Utilization Review Team (URT) or Family Programs Office (FPO), (entities responsible for reviewing, recommending, and reviewing appropriate placement and treatment services) approves the admission/placement (does not apply to placements at State owned and operated facilities.

   b. The admission is prior authorized by the QIO-like vendor;

   c. The RTC is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and

   d. The RTC is a contracted service provider with Nevada Medicaid.

For those Healthy Kids recipients not in the custody of the DCFS, only Section 3403.1.A.2(b, c, and d) of this Chapter apply.

3. Criteria for exclusion from RTC admission

One or more of the following must be met (case-by-case clinical decisions will be addressed and based upon whether or not the client is expected to benefit from treatment and the RTC's capability to provide the service);

a. Psychiatric disorder requiring acute hospitalization, (e.g., overtly suicidal, acute psychiatric episodes, requires physical restraints).

b. Physical disability which limits the child's ability to participate fully in the program.

c. Learning disabilities (primarily based upon the individual education program/IEP); also taken into consideration are what are the child's learning capabilities, can he/she be taught, and is he/she expected to benefit or improve from treatment;

d. Impairment resulting from traumatic brain injury (TBI) (is he or she expected to improve from treatment, despite the TBI?);

e. Organic brain syndrome (primarily based upon the IEP, also taken into consideration are what are the child's learning capabilities, can he/she be taught, and is he/she expected to benefit form treatment?);

f. Pregnancy (an exception may be made if the RTC can confirm that they can appropriately meet the needs of the adolescent, including obtaining prenatal care while in the facility, and the infant is included in the post-discharge plans, if appropriate. Medicaid, not the RTC, would pay for such costs associated with the medical care of the infant);

g. Chronic violent behavior incompatible with a group living environment which poses unacceptable and unsafe risks to other clients or staff for any reason (i.e., a danger to self, others or property);

h. Medical illnesses severe enough to limit functioning in the school programs, or beyond the center's capacity for medical care, including but not limited to:

1. Diabetes
2. Hemophilia
3. Contagious airborne disease
4. Epilepsy, etc.

i. Drug or alcohol detoxification is required as a primary treatment modality;

j. A diagnosis of Oppositional Defiant Disorder (ODD) and/or Conduct Disorder, alone and apart from any other DSM-IV Axis I or Axis II diagnosis;

4. Therapeutic Home Passes

Therapeutic home passes are instrumental and often necessary in facilitating a recipient's discharge out of the RTC, whether back to the child's home or other lower level alternative setting.

Nevada Medicaid permits RTC recipients to utilize, based on case-by-case recommendations of the RTC clinical treatment team, a total of 20 days per recipient per calendar year for therapeutic home passes to facilitate a recipient's discharge plan.

In order to facilitate this leave of absence policy, the following Nevada Medicaid guidelines must strictly be adhered to. Failure to follow these guidelines will result in non-payment to RTCs during the time the recipient was away on therapeutic home pass:

a. A physician's order is required for therapeutic home passes. If the recipient is to be traveling alone, this must be specified in the physician order.

b. Therapeutic home pass information verifying days used must be included in the documentation submitted to the QIO-like vendor. This cumulative documentation must include: dates for each pass, location of the pass, pass objectives with a discussion about how the objectives were met and the number of days. (A copy of the physician order for the pass must also be submitted. Failure to submit the physician order will result in the therapeutic home pass days not being included in the certification for payment).

c. Nevada Medicaid will not allow unused pass days to accumulate from one calendar year to another and be used in the next calendar year.

d. Nevada Medicaid will not reimburse RTCs for therapeutic home pass days for any recipient exceeding a total of 12 days per calendar year. Therefore to insure proper reimbursement, it is imperative that therapeutic home pass days are accurately reported on the RTCs quarterly Prior Authorization Request form versus Patient Plan review.

e. If the recipient leaves without issuance of a home pass and returns/is returned to the RTC within three (3) days, and the absence has been appropriately documented, the RTC may continue with current pass. For those recipients who leave without a pass and being away from the RTC five (5) days or greater, and/or not having enough therapeutic home pass days available, a formal discharge and readmission must always be used.

f. In the event a recipient unexpectedly does not return to the RTC from a home visit or family emergency, and such an absence has been properly documented by the RTC, the absence will be treated as a discharge effective the day the recipient was expected to return from leave.

g. Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility. Prior authorization and certification is required for payment.

The 12-day calendar year therapeutic home pass policy applies to all Nevada Medicaid RTC recipients, regardless of the recipient's custody status.

Therapeutic home pass days begin the day the child leaves the RTC and ends one day before the child actually returns to the RTC, so long as it is before midnight. For example, if the child leaves on a Monday and returns Thursday before midnight, Thursday is not counted - Monday, Tuesday and Wednesday, or three (3) days, are counted as therapeutic home pass days. If the child returns home Thursday at or after midnight, which technically is Friday, Thursday is included and four (4) days are counted as therapeutic home pass days. Therefore, to ensure proper reimbursement, it is imperative that therapeutic home pass days are accurately reported on the RTC's Quarterly Patient Plan Reviews, submitted for review by the QIO-like vendor.

5. Transportation

Nevada Medicaid may reimburse the following RTC travel related services for the eligible child and an attendant when determined to be medically necessary:

a. Initial travel to the RTC upon admission.
b. Travel for therapeutic home passes.
c. Travel upon discharge from the RTC.

Nevada Medicaid does not reimburse for meals or lodging associated with travel.

For additional information pertaining to facilitation and coordination of transportation services. Please refer to Chapter 1900 of the Medicaid Services Manual.

6. Potential Adverse Decisions

In the event of a death, suicide attempt or very serious injury (injury requiring hospitalization inflicted by a staff member or other patient) of a child, whether or not the child is Nevada Medicaid-eligible at the RTC, Nevada Medicaid will make an administrative decision as whether to impose a ban on future Medicaid-eligible children admissions and/or remove children currently at the RTC if they are believed to be in danger. Before it removes the ban on admissions Medicaid must receive and review documents from

the RTC, including but not limited to, police, autopsy, state licensing, social services and internal death or very serious injury. Medicaid's final decision may include, but not be limited to, removing the ban, keeping the ban in place or terminating the contractual relationship with the RTC.

7. Professional Internships

a. Licensed Clinical Social Worker (LCSW) Intern

LCSW Intern means an applicant for licensure as a clinical social worker who has not yet completed 3000 hours of supervised postgraduate training, but is in the process of doing so under a program of internship approved by the State of Nevada, Board of Examiners for Social Workers (NAC 641B.035).

Internship program requirements are governed by the State of Nevada, Board of Examiners for Social Worker and Nevada Administrative Code (NAC), Chapter 641B.

Medicaid LCSW Internship Requirements:

1. Internship certificate issued by the board must be available if requested (i.e., during an audit)

2. All chart entries (i.e., assessments, treatment plans, and progress notes) must be cosigned by a supervising LCSW.

3. Weekly maximum number of twenty-five (25) clinical hours can be completed by an LCSW intern.

4. Supervisors and interns are required to meet at least once per month to discuss and review cases.

b. Licensed Marriage and Family Therapist (LMFT) Intern

LMFT Intern means a person who holds a master's degree in marriage and family therapy, or an equivalent degree from an accredited university, whose registration by the board has been approved (NAC 641A.035). Internship means an approved program of supervised and documented experience in clinical practice (NAC 641A.035).

Internship program requirements are governed by the State of Nevada, Board of Examiners for Marriage and Family Therapists and Nevada Administrative Code (NAC), Chapter 641A.

Medicaid LMFT Internship Requirements:

1. Interim permit issued by board must be available, if requested (i.e., during an audit).

2. All chart entries (i.e., assessments, treatment plans, and progress notes) must be cosigned by supervising LFMT.

3. Weekly maximum number of twenty (20) clinical hours can be completed by an LMFT intern.

4. Supervisors and interns are required to meet at least once per month to discuss and review cases.

For purposes of reimbursement, Medicaid's Internship requirements pertain to instate RTC service providers. Medicaid's out-of-state RTC service providers are expected to comply with LCSW and LMFT Internship requirements in their own state.

3403.1B PROVIDER RESPONSIBILITIES

1. Each RTC must agree to comply with the following authoritative guidelines in order to obtain reimbursement for services:

   a. Medicaid Services Manual, Chapter 3400, entitled "Residential Treatment Center (RTC) Services.
   b. Medicaid's prior authorization, length of stay and utilization review manual entitled "Residential Treatment Center Guidelines.

2. Critical Events Reporting Requirements

   RTCs are required to report (on the critical event reporting form, which may be obtained by contacting the QIO-like vendor) any critical event or interaction involving a Nevada Medicaid child or adolescent, within 48 hours of the occurrence, to the QIO-like vendor. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff's contacts, and physical, sexual, or emotional abuse allegations.

3. Regulatory and Compliance Agency Communication Reporting Requirements

   The "Regulatory and Compliance Agency Communication Report for Nevada Medicaid" is designed as a tool for informing Nevada Medicaid of relevant state licensing and JCAHO accreditation activities. As a contractor and partner with Nevada Medicaid in providing the best care possible to Medicaid eligible children and adolescents, this report offers RTCs an

open and ongoing mechanism to address protracted outcomes and share improvements.

On a quarterly basis, no later than 10 calendar days from the close of each quarter, the RTC must submit to the QIO-like vendor the "Regulatory and Compliance Agency Communication Report for Nevada Medicaid." (This form may be obtained from the QIO-like vendor).

4. Letter of Attestation

Federal regulations at 42 CFR 483.374 (a) require any RTC which has a contract or provider agreement with Medicaid to submit a Letter of Attestation that the facility is in compliance with CMS' standards governing the use of restraint and seclusion. Additionally, 42 CFR 483.374 (c) requires the RTC to report a resident's death, serious injury, and suicide attempt to the state Medicaid agency and state-designated Protection and Advocacy system (which in Nevada is the Nevada Disability Advocacy and Law Center). The RTC must also report the death of any resident to the CMS office no later than the close of business the next business day after the resident's death. The RTC must submit a new Letter of Attestation by the individual having legal authority (i.e., facility director, CEO, or administrator) to verify compliance with seclusion and restrain standards is no longer with the facility.

5. Quality Improvement Studies

Quality Improvement Studies help to promote the most effective and efficient use of available health care facilities and services consistent with recipient needs and professionally recognized standards of care. Medicaid requires each RTC to submit a minimum of one Quality of Care/Quality Improvement study to the QIO-like vendor annually (by March 31). RTCs may choose their own topic of interest.

6. Civil Rights Compliance

Please refer to Chapter 100 of the Medicaid Services Manual.

7. Quarterly Family Visits

If and when clinically indicated by the Medicaid recipient's interdisciplinary treatment team, when the family resides 200 miles or more from the child's placement, it is the responsibility of out-of-state and in-state RTCs to bring families (up to two people) of eligible children and adolescents to the facility on at least a quarterly basis. The purpose of these visits is to afford the family an opportunity to participate in the recipient's treatment and discharge planning. This includes the RTC providing a plane ticket, hotel arrangements, and meals, these are not reimbursable through Nevada Medicaid

Regarding Medicaid eligible children and adolescents who are in the custody of DCFS, consultation with the DCFS clinical resource representative, pertaining to the medical

necessity and appropriateness of arranging family visits for parents of DCFS custody, Medicaid eligible children on a quarterly basis, is required.

8. Discharge Accompaniments

RTCs must assure, at a minimum, the following accompany the Medicaid eligible child or adolescent upon discharge:

a. At least a one week supply of medications.

b. The child's most recent Medicaid eligibility card.

c. All pertinent medical records and post discharge plans.

9. Clinical Requirements

a. The RTC program must have a medical director who is a board-certified/board-eligible psychiatrist and has overall medical responsibility for the program. In the case of children and adolescents, the psychiatrist should be board-certified/board-eligible in child and adolescent psychiatry.

b. Medicaid eligible children and adolescents must receive, at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist. In addition, a psychiatrist must be available 24 hours a day. Routine assessments are performed to effectively coordinate all treatment, managed medications trials and/or adjustment, to minimize serious side effects, and provide medical management of all psychiatric and medical problems.

c. Clinical psychotherapy (individual, group, family, etc.) must be provided by a licensed Master's level clinician (LCSW or MFT) or psychologist. Mental health professionals (aides, technicians) are permitted to provide only educational and milieu group services. Consultation from a Ph.D Psychologist must be available in RTCs if requested.

10. Patient Rights

Pertaining to the RTC's responsibilities of protecting and promoting each patient's rights, please consult the following authorities:

a. 42 CFR 482.13.

b. Nevada Revised Statutes (NRS) 449.730.

c. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

"Restraint and Seclusion Standards for Behavioral Health." (Available at the following website: www.JCAHO.org)

11. Federal RTC Admission Requirements at 42 CFR 441.151 to 441.156 addresses certification of need, individual plan of care, active treatment and the composition of the team developing the individual plan of care.

12. Quality Improvement Organization (QIO-like vendor)

The Quality Improvement Organization (QIO-like vendor) contracts with Medicaid to provide utilization and quality control review of Medicaid inpatient psychiatric hospital, RTC admissions. Within the purview of the QIO-like vendor's UR responsibilities are admission and length of stay criteria development, prior authorization, concurrent and retro-eligible review, certification, and reconsideration decisions.

Any hospital or RTC which alters, modifies or changes in any way, any QIO-like vendor certification, will be denied payment.

13. Eligibility Information

Obtaining information regarding recipient eligibility is the provider's responsibility. Information concerning pending or eligible recipients should be obtained from the recipient or recipient's family at the time of treatment. Sources of eligibility information for the month of service could include the recipient's monthly eligibility card, the responsibility for payment form (required by most providers), which is signed by the recipient, other medical providers, or the Electronic Verification of Eligibility system (EVE), which permits the provider internet access to Medicaid eligibility information.

3403.1C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients, their families, or legal guardians are required to provide a valid monthly Medicaid eligibility certificate to their RTC service providers.
2. Medicaid recipients, their families, and/or legal guardians are expected to comply with the recipient's treatment, care and service plans, including making and keeping medical appointments.

3403.1D AUTHORIZATION PROCESS

1. Completion of a Residential Treatment Center Prior Authorization Request Form which shall include a comprehensive psychiatric assessment current within six months at the request for RTC admission.

2. A Certification of Need (CON) must accompany a Prior Authorization Request Form signed by a physician and documenting the current functioning of the child, including the strengths

and weaknesses, a DSM-14 diagnosis, all past hospitalizations and current medications.

b. Before issuing a prior authorization, the QIO-like vendor must verify and ascertain:

1. Is the child truly appropriate for an RTC placement, or does the discharge planning/placement entity just need a place for the child to go?

2. What, if anything, has been attempted at a less restrictive environment or level of care (e.g., outpatient, day treatment, group or foster placement)?

3. Are up-front and in-advance post-discharge resources accessible and available?

4. Is there evidence that family members will be involved with the child's treatment at the RTC?

5. For Medicaid RTC placements involving County Probation and Youth Parole children, is there evidence the child or adolescent's behavior is truly criminal and perhaps untreatable in other than the criminal justice system?

c. If the RTC transfers the recipient to an acute psychiatric hospital or unit on an emergency basis, the QIO-like vendor must be notified for authorization purposes within 24 hours or the first working day following the transfer. If the transfer is not emergent in nature, authorization must be obtained from the QIO-like vendor prior to the transfer.

For purposes of Medicaid mental health services, an emergency inpatient psychiatric admission must meet at least one of the following criteria:

1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 30 days; or

2. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g., note) or means to carry out the suicide threat (e.g., gun, knife, or other deadly weapon); or

3. Documented aggression within the 72-hour period before admission:

a. Which resulted in harm to self, others or property;

b. Which manifests that control cannot be maintained outside of inpatient hospitalization; and

c. Which is expected to continue if no treatment is provided without

treatment.

d. A prior authorization from the QIO-like vendor is required for any in- or out-of-state acute psychiatric hospital that admits a recipient from its own in-house RTC unit. The purpose of this authorization is to determine medical necessity and the need for the acute services.

e. A prior authorization from the QIO-like vendor is required to return a recipient to the RTC from acute care, whether or not the acute hospital is part of, or separate from, the RTC. A summary of the acute treatment required and changes in recipient status and needs must be provided at the time of the authorization request.

f. An authorization is required prior to transferring a recipient to another residential treatment center. Transfer authorization will only be granted if the recipient requires services that are not available at the discharging RTC.

g. Prior authorization is required for all in and out-of-state RTC admissions for Medicaid eligible recipients. This prior authorization requirement pertains to recipients who have Medicaid only coverage, or Medicaid and primary insurance (i.e., CHAMPUS/Tri-Care, private) coverage. With the exception of Indian Health Services, (IHS), Bureau of Family Health Services and State Victims of Crime, Medicaid coverage and payment is secondary to all other payers.

   Should an RTC patient, who was not eligible on admission, become Medicaid eligible following admission, the RTC must contact the QIO-like vendor for a retro-eligible review, and, if determined medically necessary, the QIO-like vendor will issue an authorization.

h. Complete requests for prior authorization must be submitted to the QIO-like vendor no less than five (5) days prior to the admission/transfer. This allows the QIO-like vendor sufficient time to evaluate the medical necessity and appropriateness of the request. Once all required information is received, the QIO-like vendor will make the authorization determination within five (5) working days. Prior to issuance of the prior authorization, the RTC must contact the QIO-like vendor to confirm the actual date of admission. The QIO-like vendor will then forward the authorization to the RTC.

i. Those Residential Treatment Center (RTC) and acute psychiatric hospital admissions not prior authorized per the above guidelines will not be certified for payment.

2. Review Concurrent/Continued Length of Stay (LOS) authorization (following admission of Medicaid eligible recipients - this is the responsibility of the RTC)

a. If an RTC has determined it is not clinically appropriate to discharge a child, the RTC must submit, prior to the expiration of the first two-month authorization (no later than the 15th of the month in which the authorization expires), copies of the following to the QIO-like vendor:

Residential Treatment Center Services Concurrent (continuing stay) review request form (the CON is not required for concurrent or continued stay authorization.

b. Failure to submit the required documentation and/or timely will result in non-certification (denial) of the recipient's continued stay.

c. Upon approval of each two-month or less authorization, a certification for each month will be issued within 14 days of receipt of the information from the RTC. Each authorization will be issued for the next two months, or less as deemed medically necessary.

d. A copy of the discharge summary must be submitted within 30 days of the recipient's discharge from the RTC. The QIO-like vendor must receive verbal or faxed notification of all discharges within 24 hours of the discharge.

e. Continued stays for recipients for whom the RTC has not provided the required documentation on a timely basis will be subject to denial. The RTC has 30 days to request reconsideration of the denial per Section 3404 of this Chapter. Reconsideration requests received after this time frame will remain denied.

3. Retrospective Reviews

The QIO-like vendor authorizes only Medicaid eligible recipients, not pending eligible. Should a client become Medicaid eligible after discharge, a retrospective review must be requested by the provider of the QIO-like vendor. If a recipient becomes eligible while in the facility, the RTC must initiate the concurrent review process.

a. The medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination.

b. If the information submitted is not complete, a technical denial for service will be issued.

c. The QIO-like vendor will complete the review and issue a final determination within 30 days of receipt of all requested information.

4. Determination Letters (Notices)

a. Approvals

The RTC provider is sent a "Notice of Medical Necessity Determination."

b. Denials

The RTC provider is sent a Notice of Medical Necessity Determination" and "Request for Appeal" form. The Medicaid recipient is sent a "Notice of Decision (NOD) for Payment Authorization Request Form" and "Hearing Information and Hearing Request Form."

c. The QIO-like vendor will issue a denial, partial denial or level of care reduction based on medical necessity or lack thereof. These level of care determinations are issued for, but are not limited to:

1. The service(s) is/are not shown to be medically necessary.

2. The service(s) exceeds Medicaid program limitations.

3. The level of care is not shown to be met and is more restrictive than necessary.

4. Specialized services are not shown to be required.

5. The Medicaid recipient has requested the service(s) to withdrawn or terminated.

6. The service(s) is/are not a Medicaid benefit.

7. A change in federal or state law. The recipient is not entitled to a hearing.

Please consult Medicaid Services Manual Chapter 3100 entitled "Medicaid Hearings Procedures" if additional information is required.

5. Reimbursement

Nevada Medicaid reimburses RTCs a negotiated, all-inclusive daily rate. Medicaid uses three criteria when negotiating and setting rates for its RTC service providers, which are:

a. An analysis by the Division of Health Care Financing and Policy's Rates and Cost Containment Unit of the most current cost report information filed by the RTC (HCFA 2252 or equivalent).

b. The average or mean rate Nevada Medicaid reimburses its current RTC providers, both in-state and out-of-state.

c. For out-of-state RTC service providers, the rate the RTC receives, if any, from its own state Medicaid program or child welfare agency.

Medicaid's all-inclusive daily rate to RTCs includes room and board, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, milieu and recreation therapies, nursing services, all medications (for Axis I, II, and III diagnosis), educational/academic services, quarterly family (RTC-sponsored) visits, and supervised work projects.

The all-inclusive daily rate does not include general physician (non-psychiatrist) services, dental, optometry, durable medical equipment radiology, lab, and therapies (physical, speech and occupational). All of these services are Nevada Medicaid benefits which must be prior authorized by QIO-like vendor and billed separately by the particular service provider. (Please refer to Section 3405 of this Chapter for specific references to other chapters covering these services).

6. Other Insurance Coverage

Medicaid is always the payer of last resort when any other resource is responsible for payment. Other medical resources include, but are not limited to, Medicare, private insurance, and self-insured plans. The exception to this are Indian/Tribal Health Services, Children with Special Health Care Needs (formerly Crippled Children Services) and State Victims of Crime. Medicaid is a prior resource only for these programs. Billing of other third party resources is mandated by federal and state law, and is one of the provider contract provisions required of participating Medicaid service providers.

If other health coverage has been identified on the Medicaid system and the prior resource has not been billed and the service(s) is/are a covered benefit of the other health care coverage, the QIO-like vendor will not issue a certification.

3404 HEARINGS

Please reference Medicaid Services Manual, Chapter 3100 Hearings, for hearings procedures.

3405 REFERENCES AND CROSS-REFERENCES

A. Please consult other Medicaid Service Manuals which may correlate with Chapter 3400, Residential Treatment Center (RTC) Services:

1.	Chapter 100 -	Eligibility, Coverage and Limitations
2.	Chapter 200 -	Hospital Services
3.	Chapter 400 -	Mental Health and Substance Abuse Services
4.	Chapter 600 -	Physician Services
5.	Chapter 1000 -	Dental Services
6.	Chapter 1100 -	Ocular services
7.	Chapter 1300 -	Durable Medical Equipment (DME) Services
8.	Chapter 1700-	Therapy Services
9.	Chapter 1500 -	EPSDT (Healthy Kids)
10.	Chapter 1900 -	Medical Transportation Services
11.	Chapter 2500 -	Targeted Case Management Services
12.	Chapter 2900-	Mental Health Rehabilitative Treatment Services
13.	Chapter 3100 -	Medicaid Hearings Procedures
14.	Chapter 3300 -	Surveillance and Utilization Review Section (SURS)
14.	Chapter 3600 -	Managed Care Organization
15.	Chapter 3700-	Nevada Checkup

B. State Offices

Nevada Division of Health Care Financing and Policy
Nevada Medicaid Office
1100 E. Williams Street, Suite 101
Carson City, Nevada 89701
Telephone: (775) 684-3600

Nevada Division of Health Care Financing and Policy, Medicaid District Offices, (D.O.s) are listed in various Medicaid pamphlets. Local telephone numbers are:

Carson City	(775) 684-0800
Elko	(775) 738–1191
Fallon	(775) 423–3161
Las Vegas – Belrose	(702) 486–1550
Reno – Bible Way	(775) 448-5000

3405.1 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS
Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS
First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT
First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238